

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05868 # 148

Reg. Dist. No. 51

1. PLACE OF DEATH:

County CalvertCity or town Chesapeake Bay
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County CalvertCity or town Crown Beach
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Jack Dalrymple

3. (b) Social Security Number

4. Sex

male

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

Sept 14, 1931

8. AGE:

15 Years9 Months7 Days

If less than one day

hrs.min.

9. Birthplace

Topeka, Kansas
(Town, county, and state)

10. Usual occupation

Student

11. Industry or business

FATHER

12. Name

Jack Dalrymple, Sr.

13. Birthplace

MD

MOTHER

14. Maiden name

Nazel Dunn

15. Birthplace

MD

16. Informant

May Clayton

Address

1409 G St. N.E. Wash. D.C.

17.

(Burial, cremation, or removal. Which?)

Burial

Date thereof

July 28, 1947
(month) (day) (year)

Cemetery or crematory

Arlington Cemetery

Location

Arlington, Va.

18. Funeral director

S.H. Hine

Address

2901 14th St. N.W., Wash. D.C.

19.

(Date rec'd by registrar)

7-241947N.W. Ward

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

7/211947

at

6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw him _____ alive on _____

Immediate cause of death

drowning

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Accident

Date of

7/21/47

Where did injury occur?

Ches. Bay.
(City or town)Cal.
(County)MD.
(State)

Injured at home, farm, industry, public place (where?)

Free from boat

Means of injury

drowning

Injured at work?

23. SIGNATURE

H. W. Ward

M. D. or other

Address

Quinn's MD.

Date signed

7/25/47

RECEIVED
JUL 30 1947
BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

05869

CERTIFICATE OF DEATH

Reg. Dist. No. 52

1. PLACE OF DEATH: *Calvert*
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State.....*Md* County.....*Calvert*
City or town.....*Owings*
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME *John P Hardesty* 3. (b) Social Security Number

4. Sex *M.* 5. Color or race *W.* 6.(a) Single, married, widowed, or divorced *M.*
B.(b) Name of husband or wife.....*Emma E. Hardesty*
Feb. 18 6.(c) If alive, give age *67* years
7. Birth date of deceased (mo., day, yr.) *Jan. 3. 1872*
8. AGE: Years *74* Months Days If less than one day
.....hrs.min.

MEDICAL CERTIFICATION
20. DATE OF DEATH.....*1 July* 19*47* *11¹⁵* A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
1 May 19*47* to *2 July* 19*47*
and that I last saw him alive on.....19.....

Immediate cause of death.....*Chr. myocarditis*
Due to.....
Due to.....
Other conditions.....

(Include pregnancy within 8 months of death)
Major findings of operations.....
.....Date of op.....
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

9. Birthplace.....*Md.*
(Town, county, and state)
10. Usual occupation.....*Farmer*
11. Industry or business
12. Name.....*Benjamin Hardesty*
13. Birthplace.....*Md.*
14. Maiden name.....*Rebecca Hood*
15. Birthplace.....*Md.*
16. Informant.....*Mrs Ellis Butchkins*
Address.....*Owings Md*
17.....*Burial* Date thereof.....*July 4, 47*
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory.....*Cemetery*
Location.....*mt Harmony*
18. Funeral director.....*Mrs H. Butchkins*
Address.....*Owings Md.*
19. *July 3* 19*47* *Grace L. Hutchins*
(Date rec'd by registrar) Registrar

23. SIGNATURE.....*W. S. ...* M. D. or other
Address.....*Huntingtown Md* Date signed.....*3 July 47*

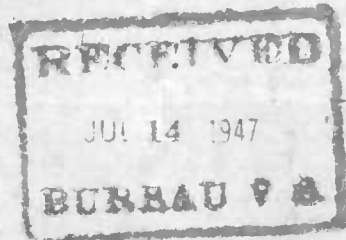
MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

74
46
28

12



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness of the information is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05870

146

P

Reg. Dist. No.

51

1. PLACE OF DEATH:

County... Calvert
 City or town... Prince Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 day
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Dist. of Col. County...
 City or town... Washington D.C.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1150 Connecticut Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war...

3. (a) FULL NAME

Arthur Mattingley

3. (b) Social Security Number

4. Sex m 5. Color or race w 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 1908 6. (c) If alive, give age... years

8. AGE: Years 79 Months Days If less than one day hrs. min.

9. Birthplace Wash. D.C.
 (Town, county, and state)

10. Usual occupation Lawyer

11. Industry or business

12. Name Wm. F. Mattingley

13. Birthplace Washington, D.C.

14. Maiden name Jennie Boone

15. Birthplace Washington, D.C.

16. Informant Col. Breckinridge

Address

17. (Burial, cremation, or removal, Which?) Burial Date thereof 7-10-47
 (month) (day) (year)

Cemetery or crematory Shannon

Location Wash. D.C.

18. Funeral director Martin W. Hyson

Address 1300 M. St., Wash. D.C.

19. July 8 47 H. W. Ward
 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 July 19 47 at 6:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 July to 7 July 19 47

and that I last saw him alive on 7 July 19 47

Immediate cause of death cerebral accident DURATION

Due to hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

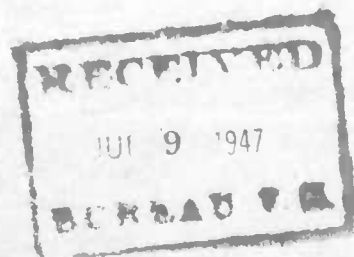
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. W. Ward M. D. or other

Address Huntingtown Md Date signed 7/8/47



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

147

05871

Reg. Dist. No. 51

1. PLACE OF DEATH:

County CalvertCity or town Sunderland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Christiana R. Rice

4. Sex

F

5. Color or race

C

6. (a) Single, married, widowed, or divorced

X

6. (b) Name of husband or wife

Joseph Rice

7. Birth date of

deceased (mo., day, yr.)

5-27-18948. (c) If alive, give age 53 years

8. AGE:

Years

Months

Days

It less than one day

53

.....hrs.min.

9. Birthplace

md

(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

MOTHER FATHER

12. Name

Bertis Jones

13. Birthplace

md

14. Maiden name

Martha A. Brown

15. Birthplace

md.

16. Informant

Joseph Rice

Address

Sunderland, md.

17.

(Burial, cremation, or removal. Which?)

Buried

Date thereof

7-8-47
(month) (day) (year)

Cemetery or crematory

St. Edmonds

Location

Calvert

18. Funeral director

P. E. Sewall

Address

Prince Frederick, md.

19.

(Date rec'd by registrar)

7-819-4-7H. W. Ward

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CalvertCity or town Sunderland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-5-47 at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2 May19447-5-471947

and that I last saw him alive on

7-41947

Immediate cause of death

Cerebral accident

Due to

Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

7 July 47

UNITED STATES DEPARTMENT OF JUSTICE

HEADQUARTERS

NOTICE TO THE PUBLIC

RECEIVED
JUL 9 1947
BUREAU V. M.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

CERTIFICATE OF DEATH

05872

Reg. Dist. No. 52

1. PLACE OF DEATH:

County CalvertCity or town Chesapeake Beach
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Joseph P. Wells, Jr.

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years 18Months 11Days 7

If less than one day

hrs. min.

9. Birthplace

Washington, D.C.
(Town, county, and state)

10. Usual occupation

None

11. Industry or business

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19. (Data rec'd by registrar)

Date signed

19. 47

Registrar

Address

Date signed

19. 47

Registrar

Address

Date signed

19. 47

Registrar

Address

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Street No.

2. (a) If veteran, name war

(If rural, give LOCATION)

MEDICAL CERTIFICATION

2D. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him

Immediate cause of death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed

19. 47

Registrar

Address

Date signed

19. 47

Registrar

Address

Date signed

19. 47

Registrar

Address

Date signed

19. 47

Registrar

Address

Date signed

19. 47

Registrar

Address

Date signed

19. 47

Registrar

Address

Mr. H. Hutchins

Livingston
Carter Co. Ind.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

47d

05873 149

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:

County Calvert Hospital
 City or town Prince Frederick
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Q.A.
 City or town Friend Ship
 (If outside city or town limits write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

MAGGIE Wilkerson

3. (b) Social Security Number _____

4. Sex

F

5. Color or race

C

6. (a) Single, married, widowed, or divorced

MARRIED

6. (b) Name of husband or wife

Augustus Wilkerson

7. Birth date of deceased (mo., day, yr.)

1877

6. (c) If alive, give age

45 years

8. AGE:

Years

Months

Days

If less than one day

70

hrs.

min.

9. Birthplace

md

(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

MOTHER FATHER

12. Name

Thomas Wilkerson

13. Birthplace

md

14. Maiden name

?

15. Birthplace

16. Informant

Augustus Wilkerson

Address

Friendship md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

7-31-47
(month) (day) (year)

Cemetery or crematory

Carters Chapel

Location

Calvert Q.A. County

18. Funeral director

P.F. Sewell

Address

Prince Frederick md.

19.

(Date rec'd by registrar)

7-3019. 47H. W. Ward

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 28, 1947, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

26 JUL 1947 to 28 JUL 1947and that I last saw h. ER alive on 28 JUL 1947Immediate cause of death EXSANGUINATION

DURATION

Due to

MASSIVE PULMONARY
HEMORRHAGE

Due to

TUMOR OF LUNG
(CANCER OF LUNG)

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Friendship, md. Date signed 28 JUL 47

MAGGIE WILKINSON
F C MARRIED

41 JUL 28 1947
41 JUL 28 1947
EXPLANATION

MASSIVE PULMONARY
HEMORRHAGE
TUMOR OF LUNG
(LIVER OF LUNG)

RECEIVED
AUG 2 1947
BUREAU C B

Chief of Police
F. J. M. J.